STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

JOE MANCHIN III
Governor

JANE L. CLINE
Insurance Commissioner

July 12, 2010

Dear Industrial Council members:

Unfortunately other commitments prohibit me from being at this July Industrial Council meeting. I did however want to provide you with some information and thoughts about Rule 22 and its role in assuring that injured workers receive the proper care as required by our law, and that insurance carriers and self insured employers are aware of the standard to which they will be held.

The Workers' Compensation System

It is important to note that the workers' compensation laws provide employers immunity from litigation due to injuries occurring as a result of work related activities. In exchange, employees receive wage replacement and appropriate medical care designed to achieve maximum medical improvement in the shortest time period possible. The proposed rule is intended to comply with that requirement and, as you know, has been limited to only those treatment requests that we believe can be most harmful to an injured worker if inappropriately denied.

The OIC, and by extension the Industrial Council, is ultimately the protector of the system to assure that the agreement between employers and employees is implemented in an equitable manner. We are acutely aware that the employers will suffer monetary losses if the system becomes inefficient. If the injured worker on the other hand is not provided the adequate treatment mandated by the law, the risk is personal and possibly permanent damage. We must be mindful that unlike most other forms of insurance covering damages we are fixing a human being, not a material possession. As such our duty is to establish rules that promote the delivery of appropriate care while being mindful not to promote economic inefficiencies. Proposed Rule 22 does that.

Cost

To assure that this rule would not place an unreasonable economic burden on the system, we asked the NCCI to review the proposed rule and opine on its economic affect. I believe you have been apprised that they find "only negligible cost" to implementing this rule. We have heard that certain members of the business community believe that this rule will be costly; however I am not aware of any research or informed opinion that supports that contention.

For your information NCCI is the only organization that we are aware of that has sufficient national data and established expertise in workers' compensation necessary to evaluate rules such as the one proposed. Certainly as the statistical agent for West Virginia NCCI is the only organization that has complete workers' compensation data pertaining to our state. They are the organization that the legislature relies upon to evaluate workers' compensation issues and they file the West Virginia loss costs for our approval. Loss costs are subsequently utilized by all carriers offering workers' compensation coverage in our state to establish premiums. As a reminder, loss costs have been reduced by a cumulative 40% since the privatization of the workers' compensation system in our state, saving employers hundreds of millions of dollars in premiums. This reduction has occurred even though medical inflation has increased significantly during the past five years. A significant part of the reduction is attributable to the proper management of claims that the insurance industry strives to accomplish. The insurance industry does not object to the proposed rule given that the rule is compatible with current industry practices.

Medical Treatment for the Injured Worker

Many examples exist in our system of injured workers being inappropriately denied medical treatment or prescriptions only to end up requiring expensive procedures that would not have been necessary had proper treatment been permitted. This is an undesirable outcome for all. Inappropriate denials have led to delay in obtaining a needed prosthetic for an amputee, seizures that were preventable and the need for unnecessary surgeries. I do not believe this is remotely acceptable to the injured worker and this type of result causes undo expense to the system.

It is important to note that virtually all carriers and self insureds use a medical network consisting of preapproved providers. This means that the denial of a request for treatment is a denial of an employer-approved physician. This is in contrast to the system in Virginia, for example, that has no official managed care system for workers' compensation and which essentially prohibits the employer from medically managing the claim. Any denial of requested treatment requires litigation.

As further testament to the appropriateness of this rule it is important to note that insurance carriers and, the administrators of the "Old Fund" claims since 2008, routinely follow the proposed procedure and consider it to be the best practice to achieve maximum medical improvement in a timely manner. This group represents 87% of the workers' compensation market. Further, this procedure is compliant with URAC standards. This rule will also provide insures and self insured employers with a standard to assure compliance with the statutory requirement to provide reasonable and medically necessary treatment to injured workers. Compliance with this standard logically leads to minimizing litigation, internal grievance activity and regulatory penalties. This should be a welcome change for all involved in the workers' compensation system.

Carriers are aware that achieving the best outcome for an injured worker is not only the required outcome but ultimately the least costly. Frankly, allowing a medical decision made by a medical trained provider to be denied by someone medically untrained cannot possibly be considered by a reasonable and prudent person as desirable.

We are aware that bad medical decisions have been and continue to be made. You have been provided with information by the Chief Judge of the Office of Judges that over 350 denials for requested medical procedures were overturned in 2009. This by no means accounts for the injured workers who do not have the wherewithal to file written protests and thus do not receive appropriate care. The result is that over 350 injured human beings in that one year alone have suffered needlessly and perhaps will never achieve maximum recovery, return to work or are forced to obtain the treatment through another source. The latter places a burden on other health care coverage or social services.

In order to vote on this rule, you must ask yourself how many injured workers suffering needlessly are acceptable. Implementing our system in the manner proposed, especially given the opinion of experts that doing so would have only negligible cost, is the best way to achieve the goals of the workers' compensation system and is consistent with national trends. You must keep in mind that not providing the proper care in a timely manner increases the cost of claims thus increasing future loss costs and ultimately the premiums paid by employers.

My responsibility is to ensure that the workers' compensation system is fair and balanced for injured workers, employers and insurers providing coverage in West Virginia. The business and employer community has benefited greatly from the work my staff and I have been doing to implement the privatization of our workers' compensation system. The injured workers deserve to benefit from the privatization as well.

Sincerely,

Jane L. Cline
Insurance Commissioner

OIC RESPONSE TO QUESTIONS FROM MEMBERS OF THE INDUSTRIAL COUNCIL CONCERNING RULE 22

The Offices of the Insurance Commissioner (OIC) received specific inquires from three members of the Industrial Council. In response to those inquiries, OIC provides this consolidated response.

I. COSTS

Questions:

Several inquiries concerned the projected cost of implementing Rule 22 to the business community. These inquiries requested information regarding general costs for implementing the rule as a whole, and specific costs associated with section 85-22-4, which deems a request approved if the responsible party fails to timely acknowledge a request for treatment. The OIC also received a request that its responses to these inquiries be "specific."

Response:

In order to determine the financial impact of Rule 22, the OIC has consulted with NCCI, OIC's statistical agent responsible for loss costs analysis for West Virginia. NCCI manages the nation's largest database of workers' compensation insurance information. Its job is to analyze industry trends; prepare rate and advisory loss cost filings; manage residual markets; maintain the workers' compensation infrastructure of classifications, rating rules, plans and forms; production of experience ratings; determination of the cost of proposed legislation (such as this rule); and many other services. NCCI is also the statistical agent for over 35 other states around the country.

Because NCCI is the OIC's provider of statistical and actuarial services, the study performed by NCCI constitutes the OIC's study on the potential cost of implementing Rule 22, and is the most accurate and specific actuarial information available. NCCI has indicated that the costs associated with the rule are "negligible" and too small to quantify with specificity. The Random House Dictionary (2010) defines "negligible" as "so small, trifling, or unimportant that it may safely be neglected or disregarded."

With regard to costs associated specifically with section 85-22-4, such costs would be represented within NCCI's assessment of the costs associated with the entire Rule. Any specific assessment of costs associated with this portion of the Rule, beyond NCCI's findings that these costs are "negligible" is not possible, because any costs associated with section 85-22-4 would be entirely determined by failure to comply with the Rule. Assuming that responsible parties complied with the requirements of the Rule, there would be no costs whatsoever associated with this section of the Rule.

II. OTHER JURISDICTIONS

Questions:

Several inquiries regarding how the issue of medical review has been addressed in other jurisdictions have been received. These inquires addressed the prevalence of medical review requirements general, and, if such review was required, whether it was mandated that this review be performed by a licensed physician. One inquiry also asked whether any other jurisdictions had requirements similar to section 85-22-4, under which a request that is not timely acknowledged is deemed to be approved.

Response:

The OIC has conducted a survey of the forty-nine other states and the District of Columbia regarding this issue, and has combined that information with responses to a survey conducted by the IAIABC; accompanying this response is a document detailing the responses received. Of the thirty-six jurisdictions responding to the survey, 25 specifically require medical review by law for all denials (not limited to three areas as proposed under Rule 22), and 17 of these jurisdictions specifically require review by a licensed physician. One other jurisdiction (NY) requires medical review by a physician in cases where the requested treatment exceeds $1,000.00 in value. With regard to the remaining jurisdictions, the applicable law ranges from no review required whatsoever (fourteen jurisdictions) to regulatory schemes or practical application that provide commensurate protections. For example, in Virginia, no medical review is required. However, care of the claimant is managed not by the carrier, but by the claimant's treating physician, and the carrier must seek review by an administrative law judge for the denial. In Maryland, there is no formal review requirement, but medical review is utilized in accordance with an informal agreement with the state regulator. Because the specific provisions of statutes and regulations vary significantly from state to state, it is difficult to make direct comparisons. However, our data indicate that utilization review in some form or another is the norm rather than the exception across the country.

It is unknown whether any other state provides claimants with the remedy set forth in section 85-22-4. It is important to note that the vast majority of treatment of injured workers is provided by physicians in a network approved and selected by the insurer or self-insured employer. Therefore, a denial of treatment without proper medical review is a denial by an adjuster without a medical degree who has overruled the opinion of that approved provider.

III. CONFLICT WITH RULES 1, 20, AND 21.

Questions:

The OIC has been asked to "clarify the apparent conflicts" between Rules 1, 20 and 21, and to explain the interaction between these rules and Rule 22.

Response:

Rule 1 includes several deadlines for acting on various matters as they arise within claims. Proposed Rule 22 does not interfere in any way with Rule 1 or its requirements. There is only one provision in Rule 22, subsection 4.1., that sets forth a time standard. This subsection requires a responsible party to "acknowledge in writing" any treatment request (as defined in the limited manner set forth in subsection 2.8) within 15 working days of receipt of the same.

Rule 1, subsection 10.3 requires a responsible party to "act upon" a medical treatment request within 15 working days from receipt. The term "acted upon" is defined in subsection 2.1 of Rule 1 as any one of the following: 1) received and processed; 2) contacted a claimant, employer, or medical provider in any fashion requesting more information; 3) reviewed and examined by medical personnel; 4) conducted a potential overpayment analysis; 5) cross-checked with other state agencies for relevant information; and 6) other similar administrative steps which must be taken before a request can be ruled upon. Clearly, Rule 1 already contemplates a broad array of actions that can be taken once a medical treatment request is received in order to begin "acting upon" the request within 15 working days. Obviously, if the request can be authorized or denied within 15 working days, then that should be done, but Rule 1 does not require authorization or denial within that time period. Arguably, compliance with subsection 4.1 of Rule 22 is also compliance with subsections 2.1 and 10.3 of Rule 1. In addition, the responsible party must continue to administer the request as contemplated by Rule 1. However, the requirements of the two rules are not inconsistent with one another.

Rule 20 sets forth treatment guidelines in a number of areas. Under Rule 20, treatment that is within these guidelines is presumed to be appropriate, while treatment outside of these guidelines is presumed to be medically inappropriate. The commentary received during the public comment period on Rule 22 regarding the alleged conflict between Rule 20 and Rule 22 universally asserted that Rule 20 alone provides an adequate basis for denial of treatment in excess of the guidelines set forth therein, and therefore obviates the need for any medical review. However, Rule 20 does not provide, and was never intended to provide, a bright-line test for the denial of medical treatment. As noted by several commentators, W. Va. Code §§ 23-4-1 and 3, require that medical treatment which is medically necessary and reasonably required to treat the occupational injury or disease be authorized. As such, the Rule 20 guidelines, standing alone, cannot be the basis for a denial of treatment; West Virginia law still requires that a denial be premised upon a determination of medical necessity. In the limited number of situations delineated in Rule 22, that determination of medical necessity would be made by a physician rather than an adjuster.

Rule 21 relates to approved Managed Health Care Plans. The OIC received comments during the public comment period on Rule 22 that asserted that Rule 22 would conflict with the provisions of Rule 21. Under Rule 21, a responsible party must have an expeditious, informal procedure to resolve disputes by employees and providers relative to the rendition of medical services prior to litigation. The comments received were

unclear regarding the nature of the alleged conflict, but the Insurance Commissioner disagrees that any conflict exists. The assertion that Managed Health Care Plans should be exempt from the Rule 22 medical review is based on the apparent belief that all negative decisions regarding surgery, DME or prescription drugs are grieved by claimants and that they will eventually get the benefit of a physician's review. We know that this is not true. It must be noted that Rule 22 is complied with by a review by the Plan's Medical Director (which all approved plans must have under Rule 21) which is not an extra expense for the plan. It assures that every claimant, not just those who have the wherewithal to file a grievance, receive the benefit of having his/her surgery, DME or certain prescriptions denied by a physician rather than an adjuster. Finally, Rule 22 requires a medical review in only the very limited circumstances set forth in the rule. The grievance process applies to every medical request. Therefore, to suggest that Rule 22 medical review duplicates the grievance process in a costly or inefficient way is incorrect. Requiring that denials, in the limited number of circumstances, be approved, for example, by a claims administrator's medical director, in no way interferes with the internal grievance process.

IV. NECESSITY OF THE RULE/OTHER REMEDIES

Questions:

The OIC has been asked why the OIC believes Rule 22 is necessary, what is the scope of the problems the Rule seeks to address, and why the Rule should be applied to the entire market rather than the OIC using its oversight authority to take narrow action against specific responsible parties that are cause for concern.

Response:

The scope of the problem is impossible to enumerate with precision, but there is no question that there is a problem with denials of medical treatment in the administration of workers' compensation claims in West Virginia. The OIC undertook a survey of consumer complaints filed with the agency between January 1, 2006 and September 30, 2007, and has identified 189 complaints regarding the denial of medical treatment during that period of time. Additionally, Chief Administrative Law Judge Rebecca Roush has already reported to the Industrial Council that out of the total number of medical treatment issues heard in 2009 (1412), 25% were reversed. This means that the Office of Judges determined on about 350 occasions in 2009 that a denial of medical treatment was inappropriately made. That number represents 350 people who likely didn't receive the benefit of the best decision that could have been made in their claim. It is also important to recognize that protests and complaints represent only a portion of the universe of claims where treatment may have been inappropriately denied. Both protests and complaints require affirmative action by a claimant with sufficient administrative know-how to navigate the system, and not all claimants will take such action.

The question presented with regard to necessity is a simple one: Given that medical review can be provided in the limited circumstances covered by Rule 22 at a cost that is

"so small, trifling, or unimportant that it may safely be neglected or disregarded," why would any number of incorrect denials of surgery, durable medical treatment or prescription drugs that have enabled a claimant to reach maximum medical improvement be acceptable? NCCI, in fact, points out that not providing appropriate care in a timely manner ultimately increases the cost of a claim.

The OIC, as the system's regulator, considers Rule 22 to be a reasonable claim handling standard that is appropriate for all claims. All claimants deserve to have appropriate medical personnel making decisions to deny the limited types of medical treatment issues outlined in the rule. The decision to implement this reasonable standard, which the NCCI has opined is of negligible cost, should not turn on whether some number of otherwise "acceptable" number of incorrect denials has been exceeded.

In addition, consumer complaint data simply isn't helpful to the analysis of proposed Rule 22 because it is of limited value in resolution of treatment denials, for the following reasons:

- Unlike other types of P&C or casualty claims, all decisions in a workers' compensation claim are final unless a claimant files a written protest within the statutorily mandated administrative process (starting with the Office of Judges) within 60 days of that decision. This 60 day time limit is a condition of the right to litigate the decision and hence jurisdictional.

- When a claimant files a consumer complaint with the OIC's Consumer Services Division, it is reviewed and unless the action complained about is based on already established facts that are not in dispute and represents a clear violation on its face (e.g. a deadline is missed) the claimant is advised that he/she must file a protest with the Office of Judges and litigate the decision.

- The OIC through its consumer complaint process is not set up to be a "trier of fact" in workers' compensation claims. The OIC cannot promote a consumer complaint system that will result in action that is inconsistent with the administrative law decision from the Office of Judges, Board of Review and Supreme Court of Appeals.[1]

Likewise, Market Conduct is not the best solution for the specific concerns that Rule 22 was proposed to address. Market Conduct is very appropriate for measuring whether certain standards have been met in workers' compensation claims. However, the Market Conduct staff are not physicians and are therefore not qualified to determine whether a specific denial of medical treatment has caused a particular claimant to have a worse

[1] By statute, appeals in workers' compensation claims from the Office of Judges go to the Board of Review and from there to the Supreme Court. In sharp contrast, when a consumer complaint relating to auto, homeowners, health or other insurance line is set for hearing before a hearing examiner appointed by the OIC under the state's Administrative Procedures Act, appeals go to the Circuit Court of Kanawha County. Clearly, the consumer complaint process is an entirely inappropriate vehicle for the litigation of a workers' compensation decision dispute.

medical outcome than had the treatment been allowed. The OIC's assumption is that a denial of medical treatment by a physician is more likely to be based on an understanding of the claimant's medical condition(s) and what is medically necessary and reasonably related to compensable condition(s) in the claim than a non-medically-trained adjuster's decision; and whether a physician reviewed a claim file prior to a decision to deny surgery, for example, is a measurable event that can be effectively reviewed by Market Conduct.

The requirement of medical review is a growing trend across the country although states achieve the intent of proposed Rule 22 in a variety of ways. Because of the variation and the many uses of the words "medical review" and "utilization review" it is difficult to research and is not an apples to apples comparison among the states. It is very significant the insurance industry outside of WV does not oppose the rule. These are the entities that understand how claims are managed medically. If medical review were a novel concept, the OIC would have received negative comments from the insurance industry. We know the carriers and their management and representatives and they know how to oppose actions that we propose, yet they have not opposed this rule.

The rule will improve claim handling by ensuring that medical doctors approve a denial of certain medical treatments or drugs. It is a measurable standard that can be reviewed by market conduct staff – did or did not the responsible party have a medical review of the file prior to the denial? The OIC believes that this alone will ensure more appropriate medical decisions. The rule won't make bad people good – no rule can do that. But it will provide a common, measurable, inexpensive and reasonable standard for handling all claims in our State. Now, without the standard established by this rule, market conduct examiners with no medical training have no basis for reviewing whether a medical treatment denial was appropriate.

V. MISCELLANEOUS

Question:

How will this rule impact processes already in place by companies to address getting adequate information from doctors to make timely decisions regarding treatment?

Response:

This rule will not interfere with a responsible party's need to receive adequate information in order to "act upon" a medical treatment request. When the request comes in, on the form to be promulgated by the OIC and with whatever information is required in order to "act upon" the request, and it is one of the specific types of matters that are addressed by Rule 22, then the rule must be complied with. The focus of the rule is not a timeliness issue – it is the use of a medical doctor to review a file before a denial of certain specific things. The OIC has always said that medical decisions in workers' compensation claims should be made by medical professionals, not by lawyers and Administrative Law Judges. This rule is part of that philosophy, advances the

requirement that injured workers receive appropriate treatment, and reduces litigation and the ultimate cost of claims.

Question:

Has anyone documented the assertion that any carrier using URAC or similar certifications would generally meet this requirement? Have you quantified how many carriers doing business in our state are members of URAC? And that the URAC standard requires a physician?

Response:

We have not documented the number of carriers using URAC certification. However, it is known that the majority of carriers or their vendors do utilize URAC standards. Sedgwick CMS, the largest third-party administrator in the United States, is URAC certified, and URAC's are by far the most widely used standards in the country.

Question:

The NCCI's comment on cost includes the assertion that "current practice already includes denial review by a medical professional in most cases." Assuming that is true:

- What percentage of the 25% reversals do you estimate were from carriers that did a medical review? A significant majority at least? Do you have any statistics to support that estimate?

- For the appealed decisions that didn't include a review, what percentage of the reversed appeals do you expect the physician review would have approved? Do you have any statistics or evidence to support that estimate?

Response:

The information requested is not available. However, NCCI are nationally recognized as the pre-eminent experts in workers' compensation and processes utilized.

Question:

It's been asserted that many claimants don't understand their appeal rights, and that contributes to such options, including the 'expedited litigation process' not being effective in addressing the problems cited to justify enacting this rule. What efforts does the OIC intend to make to improve the level of knowledge about the options claimants have or otherwise improve existing remedies to incorrect decisions?

Response:

There are already a number of mechanisms in place for advising and educating claimants about the remedies available to them. West Virginia Code § 23-5-1 requires that all decisions advise a claimant of the right to protest any decision entered by a claims

administrator. Additionally, the OIC has produced brochures advising claimant about the litigation process and the procedure for filing Consumer Complaints.

The OIC has no current plans for additional public education on these issues. With regard to Rule 22, the level of public understanding regarding other remedies is irrelevant; as noted in the OIC's initial response to public comments received with regard to Rule 22, other remedies are not sufficient to address the problems alleviated by Rule 22. In 2009, 350 people had needed medical treatment – medical treatment to which they were entitled to under West Virginia law – wrongfully withheld from them while they were forced to navigate the appellate process at the Office of Judges. Under those circumstances, and particularly in the narrow subset of treatment issues covered by Rule 22, the OIC does not believe that litigation, or consumer complaints as discussed above, provide a reasonable remedy to claimants.

We are mindful that the workers' compensation system provides for the release of an employer from civil liability and litigation arising from a workplace injury in exchange for the receipt of necessary medical treatment, replacement of lost wages, and compensation for any permanent disability suffered by the injured worker. It is the responsibility of the OIC and the Industrial Council to assure that this "bargain," upon which the entire system of workers' compensation is based, remains intact. Unlike other types of property and casualty insurance, workers' compensation insurance is designed to cover the healing and recovery of human beings, and not the repair of property.

MEDICAL REVIEW IN OTHER STATES - SURVEY RESULTS

Performs Medical Review | Review Done Internally by Carriers | No Review | No Response

STATE	MEDICAL REVIEW PERFORMED?	REVIEW BY LICENSED PHYSICIAN?	TIME LIMIT FOR ACKNOWLEDGEMENT?
Alabama	Yes, at request of employer	Yes	48 hours from time all documents are received
Alaska	No	N/A	N/A
Arizona	Done internally by carriers	N/A	N/A
Arkansas	Yes	Those performing UR in connection with medical treatment must be certified by the Arkansas Board of Health	3 working days
California	Yes	Yes	Within 5 business days and no more than 14 calendar days
Colorado	Yes, if request is outside of treatment guidelines	Colorado licensed physician	7 business days
Connecticut	Yes	Yes	Unknown
Delaware	Yes, through randomly selected contracted UR companies	Yes, by a "like specialist" as defined by URAC	None
District of Columbia	Yes	Yes	Unknown
Florida	Yes	No	Unknown
Georgia	Done internally by carriers	Unknown	Unknown
Hawaii	No	N/A	N/A
Idaho	Done internally by carriers	N/A	N/A
Illinois	Yes	No	Unknown
Indiana*	No	N/A	N/A
Iowa	No	N/A	N/A
Kansas	Done internally by carriers	N/A	N/A

STATE	MEDICAL REVIEW PERFORMED?	REVIEW BY LICENSED PHYSICIAN?	TIME LIMIT FOR ACKNOWLEDGEMENT?
Kentucky	Yes	Yes	Prospectively - 2 days Retrospectively - 10 days
Louisiana	Yes	Louisiana licensed physician	Verbal response within 2 business days and written response in 5 calendar days
Maine	Yes, at request of employer	Not stated	Not stated
Maryland	No	N/A	No response
Massachusetts	No	N/A	N/A
Michigan	Yes, review may be done by outside entity but it must be certified by the WC Agency	Yes	Not stated
Minnesota	No	N/A	7 business days
Mississippi	Yes, by UR agents licensed by the State Department of Health to perform those types of services	Yes	2 business days
Missouri	No	N/A	N/A
Montana	Done internally by carriers	N/A	
Nebraska	Done internally by carriers	N/A	N/A
Nevada	Done internally by carriers	N/A	N/A
New Hampshire	No	N/A	N/A
New Jersey	Yes, at request of employer	Not stated	Not stated
New Mexico	No	N/A	N/A
New York**	See below	See below	See below
North Carolina	Yes	Unknown	Unknown
North Dakota	Yes	Yes	72 hours
Ohio	Yes	Unknown	Unknown
Oklahoma	No	N/A	N/A
Oregon	Yes	Yes	Not stated
Pennsylvania	Yes, at request of employer	Yes, a provider in the same profession and having the same	No

STATE	MEDICAL REVIEW PERFORMED?	REVIEW BY LICENSED PHYSICIAN?	TIME LIMIT FOR ACKNOWLEDGEMENT?
		specialty as that of the provider of the treatment under review	
Rhode Island	No	N/A	N/A
South Carolina	Done internally by carriers	N/A	N/A
South Dakota	Yes	Unknown	Unknown
Tennessee	Yes	Tennessee licensed physician	3 days
Texas	Yes	Yes	Yes (length not specified)
Utah	Yes	Unknown	Unknown
Vermont	Done internally by carriers	No requirements	30 days
Virginia	No	N/A	N/A
Washington	Yes	Unknown	Unknown
Wisconsin	Done internally by carriers	N/A	N/A
Wyoming	No	N/A	N/A

*Indiana - Currently Indiana does not have medical review. During the last legislative session the insurance industry wanted to pass legislation in Indiana to institute it but it did not occur. The Department is currently in the process of inserting language into their Rules & Regulations to recognize this process and give some guidance in the area.

**New York - In NY, if the medical care costs more than $1000 then the provider must request prior authorization from the carrier/employer. The payer has 30 days to approve or deny the request and can only deny based on a conflicting second opinion within 30 days. A conflicting second opinion must be from a physician authorized by the Chair of the Workers' Compensation Board to conduct IME's of claimants. If the request is then denied based upon a conflicting second opinion, then the conflict must be resolved by a hearing before a workers compensation law judge. For all claims under $1000, medical review is something done internally by carriers.